



# IDAHO DEPARTMENT OF HEALTH & WELFARE

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November 24, 2008

Thair Pond, Administrator  
Tomorrow's Hope—Navarro  
1655 Fairview Avenue Suite 100  
Boise, Idaho 83702

RE: Tomorrow's Hope—Navarro, provider #13G061

Dear Mr. Pond:

This is to advise you of the findings of the Medicaid/Licensure Fire Life Safety Survey, which was concluded at Tomorrow's Hope—Navarro, on November 17, 2008.

Enclosed is a Statement of Deficiencies/Plan of Correction, Form CMS-2567, listing Medicaid deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. **It is important that your Plan of Correction address each deficiency in the following manner:**

1. What corrective action(s) will be accomplished for those individuals found to have been affected by the deficient practice;
2. How you will identify other individuals having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
3. What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur;
4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,
5. Include dates when corrective action will be completed. 42 CFR 488.28 states ordinarily a provider is expected to take the steps needed to achieve compliance within 60 days of being notified of the deficiencies. Please keep this in mind when preparing your plan of correction. For corrective actions which require construction, competitive bidding, or other issues beyond the control of the facility, additional time may be granted.

Thair Pond, Administrator  
November 24, 2008  
Page 2 of 2

Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **December 8, 2008**, and keep a copy for your records.

Thank you for the courtesies extended to us during our visit. If you have any questions, please call or write this office at (208)334-6626.

Sincerely,

A handwritten signature in black ink, appearing to read "Taylor Barkley", written in a cursive style.

TAYLOR BARKLEY  
Health Facility Surveyor  
Facility Fire Safety and Construction Program

TB/lj

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/24/2008  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13G061</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>02 - ENTIRE STRUCTURE</b> B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/17/2008</b>
NAME OF PROVIDER OR SUPPLIER  <b>TOMORROW'S HOPE - NAVARRO</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>946 NORTHWEST 12TH MERIDIAN, ID 83642</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
K 000	<p><b>INITIAL COMMENTS</b></p> <p>The facility is a single story Type V (000) residential building. It is sprinklered in living spaces and closets with quick response heads. It has a complete fire alarm/smoke detection system. Currently the building is licensed for 7 ICF-MR beds. The survey was conducted in accordance with 42 CFR 483.470.</p> <p>The following deficiencies were cited during the fire/life safety survey on November 17, 2008.</p> <p>The annual fire/life safety survey was conducted by:</p> <p>Taylor Barkley Health Facility Surveyor Facility Fire/Life Safety and Construction Program</p>	K 000		
KS152	<p><b>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD</b></p> <p>(1) The facility holds evacuation drills at least quarterly for each shift of personnel and under varied conditions to -</p> <p>(i) Ensure that all personnel on all shifts are trained to perform assigned tasks;</p> <p>(ii) Ensure that all personnel on all shifts are familiar with the use of the facility's emergency and disaster plans and procedures.</p> <p>(2) The facility must -</p> <p>(i) Actually evacuate clients during at least one drill each year on each shift;</p> <p>(ii) Make special provisions for the evacuation of clients with physical disabilities;</p> <p>(iii) File a report and evaluation on each drill;</p> <p>(iv) Investigate all problems with evacuation</p>	KS152		

**RECEIVED**  
**DEC 02 2008**  
**BUREAU OF FACILITY  
STANDARDS**

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13G061</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>02 - ENTIRE STRUCTURE</b> B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/17/2008</b>
NAME OF PROVIDER OR SUPPLIER  <b>TOMORROW'S HOPE - NAVARRO</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>946 NORTHWEST 12TH MERIDIAN, ID 83642</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
KS152	<p>Continued From Page 1</p> <p>drills, including accidents and take corrective action; and (v) During fire drills, clients may be evacuated to a safe area in facilities certified under the Health Care Occupancies Chapter of the Life Safety Code.</p> <p>(3) Facilities must meet the requirements of paragraphs (i) (1) and (2) of this section for any live-in and relief staff that they utilize.</p> <p>This Standard is not met as evidenced by: Based on record review it was determined that the facility failed to hold evacuation drills at least quarterly on each shift. In the event of an emergency the drills help to ensure that staff on all shifts are trained and react accordingly for the type of emergency. The facility had a census of 7 clients. All clients and staff present the day of the survey were effected.</p> <p>Findings include:</p> <p>During record review on November 17, 2008 at 1:47 PM, revealed that the facility did not have any documentation for having held any third shift drills and 2 second shift drills during the during the previous twelve months. These observations were witnessed and noted by facility staff and Surveyor.</p>	KS152	<p><i>KS152</i></p> <p><i>Facility will have a minimum of one Evacuation fire drill quarterly for each shift Para 9 Responsible by 12/30/08</i></p> <p><i>The Facility will ensure a minimum of one Evacuation fire drill will be made quarterly per shift. Para 9 will ensure documentation of drills are physically available for review during Monthly QA process Para 9 responsible by 12/30/08</i></p>	

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13G061</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - OLD</b> B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/17/2008</b>
NAME OF PROVIDER OR SUPPLIER <b>TOMORROW'S HOPE - NAVARRO</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>946 NORTHWEST 12TH MERIDIAN, ID 83642</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 000	16.03.11 Initial Comments  The facility is a single story Type V (000) residential building. It is sprinklered in living spaces and closets with quick response heads. It has a complete fire alarm/smoke detection system. Currently the building is licensed for 7 ICF-MR beds. The survey was conducted in accordance with applicable fire/life safety requirements set forth in IDAPA 16.03.11 Rules Governing Intermediate Care Facilities for the Mentally Retarded (ICF/MR).  The following deficiencies were cited during the fire/life safety survey on November 17, 2008.  The annual fire/life safety survey was conducted by:  Taylor Barkley Health Facility Surveyor Facility Fire/Life Safety and Construction Program	M 000		
MM309	16.03.11.110 Fire and Life Safety Standards  Buildings on the premises used as facilities must meet all the requirements of local, state and national codes concerning fire and life safety standards that are applicable to ICF/MR facilities. This Rule is not met as evidenced by: Refer to federal deficiencies listed on the CMS 2567 form:  K152- Fire Drills	MM309	MM309 Refer to Tag KS152	

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TITLE

(X6) DATE